Virginia Administrative Code

Database updated through 23:15 V.A.R. April 2, 2007

12VAC30-120-211. Definitions.

"Activities of daily living" or "ADL" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Appeal" means the process used to challenge adverse actions regarding services, benefits and reimbursement provided by Medicaid pursuant to 12VAC30-110 and 12VAC30-20-500 through 12VAC30-20-560.

"Assistive technology" or "AT" means specialized medical equipment and supplies to include devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county under Chapter 1 (§37.2-100) of Title 37.2 of the Code of Virginia that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the locality that it serves.

"CMS" means the Centers for Medicare and Medicaid Services, which is the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Case management" means the assessing and planning of services; linking the individual to services and supports identified in the consumer service plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the consumer service plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the consumer service plan.

"Case manager" means the individual on behalf of the community services board or behavioral health authority possessing a combination of mental retardation work experience and relevant education that indicates that the individual possesses the

knowledge, skills and abilities as established by the Department of Medical Assistance Services in 12VAC30-50-450.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities under Chapter 5 (§37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means, for the purpose of these regulations, a person who provides companion services.

"Companion services" means nonmedical care, support, and socialization, provided to an adult (age 18 and over). The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the consumer service plan and is not purely diversional in nature.

"Comprehensive assessment" means the gathering of relevant social, psychological, medical and level of care information by the case manager and is used as a basis for the development of the consumer service plan.

"Consumer-directed model" means services for which the individual and the individual's family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the staff.

"Consumer-directed (CD) services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and the individual's family/caregiver, as appropriate, by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed companion, personal assistance, and respite services.

"Consumer service plan" or "CSP" means documents addressing needs in all life areas of individuals who receive mental retardation waiver services, and is comprised of individual service plans as dictated by the individual's health care and support needs. The individual service plans are incorporated in the CSP by the case manager.

"Crisis stabilization" means direct intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral challenges that jeopardize their current community living situation, by providing temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means persons employed by the Department of Medical Assistance Services.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DMHMRSAS staff" means persons employed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

"Developmental risk" means the presence before, during or after an individual's birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through existing diagnostic and evaluative criteria.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts or special opportunities to eligible individuals and the individual's family/caregivers, as appropriate, as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual and the individual's family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's and the individual's family/caregiver's, as appropriate, use of the providers' services.

"Enroll" means that the individual has been determined by the case manager to meet the eligibility requirements for the MR Waiver and DMHMRSAS has verified the availability of a MR Waiver slot for that individual, and DSS has determined the individual's Medicaid eligibility for home and community-based services.

"Entrepreneurial model" means a small business employing eight or fewer individuals who have disabilities on a shift and usually involves interactions with the public and with coworkers without disabilities.

"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site (when the work site modification exceeds reasonable

accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines that prescribe preventive and treatment services for Medicaid-eligible children as defined in 12VAC30-50-130.

"Fiscal agent" means an agency or organization within DMAS or contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed personal assistance, respite, and companion services.

"Health Planning Region" or "HPR" means the federally designated geographical area within which health care needs assessment and planning takes place, and within which health care resource development is reviewed.

"Health, welfare, and safety standard" means that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written individual service plan and that services can safely be provided in the community.

"Home and community-based waiver services" or "waiver services" means the range of community support services approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to persons with mental retardation and children younger than age six who are at developmental risk who would otherwise require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR.)

"ICF/MR" means a facility or distinct part of a facility certified by the Virginia Department of Health, as meeting the federal certification regulations for an Intermediate Care Facility for the Mentally Retarded and persons with related conditions. These facilities must address the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, and must provide active treatment.

"Individual" means the person receiving the services or evaluations established in these regulations.

"Individual service plan" or "ISP" means the service plan related solely to the specific waiver service. Multiple ISPs help to comprise the overall consumer service plan.

"Instrumental activities of daily living" or "IADLs" means tasks such as meal preparation, shopping, housekeeping, laundry, and money management.

"ISAR" means the Individual Service Authorization Request and is the DMAS form used by providers to request prior authorization for MR waiver services.

"Mental retardation" or "MR" means mental retardation as defined by the American Association on Mental Retardation (AAMR).

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and DMHMRSAS, and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for services until all required information is received by DMHMRSAS.

"Personal assistance services" means assistance with activities of daily living, instrumental activities of daily living, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition.

"Personal assistant" means a person who provides personal assistance services.

"Personal emergency response system (PERS)" is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Preauthorized" means that an individual service has been approved by DMHMRSAS prior to commencement of the service by the service provider for initiation and reimbursement of services.

"Prevocational services" means services aimed at preparing an individual for paid or unpaid employment. The services do not include activities that are specifically job-task oriented but focus on concepts such as accepting supervision, attendance, task completion, problem solving and safety. Compensation, if provided, is less than 50% of the minimum wage.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

"Qualified mental retardation professional" means a professional possessing: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"Residential support services" means support provided in the individual's home by a DMHMRSAS-licensed residential provider or a DSS-approved provider of adult foster care services. This service is one in which training, assistance, and supervision is routinely provided to enable individuals to maintain or improve their health, to develop skills in activities of daily living and safety in the use of community resources, to adapt their behavior to community and home-like environments, to develop relationships, and participate as citizens in the community.

"Respite services" means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care.

"Services facilitator" means the DMAS-enrolled provider who is responsible for supporting the individual and the individual's family/caregiver, as appropriate, by ensuring the development and monitoring of the Consumer-Directed Services Individual Service Plan, providing employee management training, and completing ongoing review activities as required by DMAS for services with an option of a consumer-directed model. These services include companion, personal assistance, and respite services.

"Skilled nursing services" means services that are ordered by a physician and required to prevent institutionalization, that are not otherwise available under the State Plan for Medical Assistance and that are provided by a licensed registered professional nurse, or by a licensed practical nurse under the supervision of a licensed registered professional nurse, in each case who is licensed to practice in the Commonwealth.

"Slot" means an opening or vacancy of waiver services for an individual.

"State Plan for Medical Assistance" or "Plan" means the Commonwealth's legal document approved by CMS identifying the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with mental retardation to maintain paid employment.

"Support plan" means the report of recommendations resulting from a therapeutic consultation.

"Therapeutic consultation" means activities to assist the individual and the individual's family/caregiver, as appropriate, staff of residential support, day support, and any other providers in implementing an individual service plan.

12VAC30-120-213. General coverage and requirements for MR waiver services.

A. Waiver service populations. Home and community-based waiver services shall be available through a §1915(c) of the Social Security Act waiver for the following individuals who have been determined to require the level of care provided in an ICF/MR.

1. Individuals with mental retardation; or

2. Individuals younger than the age of six who are at developmental risk. At the age of six years, these individuals must have a diagnosis of mental retardation to continue to receive home and community-based waiver services specifically under this program.

Mental Retardation (MR) Waiver recipients who attain the age of six years of age, who are determined to not have a diagnosis of mental retardation, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for transfer to the IFDDS Waiver effective up to their seventh birthday. Psychological evaluations (or standardized developmental assessment for children under six years of age) confirming diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These recipients transferring from the MR Waiver will automatically be assigned a slot in the IFDDS Waiver, subject to the approval of the slot by CMS. The case manager will submit the current Level of Functioning Survey, CSP and psychological evaluation (or standardized developmental assessment for children under six years of age) to DMAS for review. Upon determination by DMAS that the individual is appropriate for transfer to the IFDDS Waiver, the case manager will provide the family with a list of IFDDS Waiver case managers. The case manager will work with the selected IFDDS Waiver case manager to determine an appropriate transfer date and submit a DMAS-122 to the local DSS. The MR Waiver slot will be held by the CSB until the child has successfully transitioned to the IFDDS Waiver. Once the child has successfully transitioned, the CSB will reallocate the slot.

B. Covered services.

1. Covered services shall include: residential support services, day support, supported employment, personal assistance (both consumer and agency-directed), respite services (both consumer and agency-directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, prevocational services, personal emergency response systems (PERS), and companion services (both consumer and agency-directed.)

2. These services shall be appropriate and necessary to maintain the individual in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in Intermediate Care Facilities for the Mentally Retarded under the State Plan that would have been provided had the waiver not been granted.

3. Waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facility, ICF/MR, or inpatient rehabilitation facility. Individuals with mental

retardation who are inpatients of these facilities may receive case management services as described in 12VAC30-50-450. The case manager may recommend waiver services that would promote exiting from the institutional placement; however, these services shall not be provided until the individual has exited the institution.

4. Under this §1915(c) waiver, DMAS waives §1902(a)(10)(B) of the Social Security Act related to comparability.

C. Requests for increased services. All requests for increased waiver services by MR Waiver recipients will be reviewed under the health, welfare, and safety standard. This standard assures that an individual's right to receive a waiver service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria and a written ISP and that services can safely be provided in the community.

D. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

E. Urgent criteria. The CSB/BHA will determine, from among the individuals included in the urgent category, who should be served first, based on the needs of the individual at the time a slot becomes available and not on any predetermined numerical or chronological order.

1. The urgent category will be assigned when the individual is in need of services because he is determined to meet one of the criteria established in subdivision 2 of this subsection and services are needed within 30 days. Assignment to the urgent category may be requested by the individual, his legally responsible relative, or primary caregiver. The urgent category may be assigned only when the individual, the individual's spouse, or the parent of an individual who is a minor child would accept the requested service if it were offered. Only after all individuals in the Commonwealth who meet the urgent criteria have been served can individuals in the nonurgent category be served. Individuals in the nonurgent category are those who meet the diagnostic and functional criteria for the waiver, including the need for services within 30 days, but who do not meet the urgent criteria. In the event that a CSB/BHA has a vacant slot and does not have an individual who meets the urgent criteria, the slot can be held by the CSB/BHA for 90 days from the date it is identified as vacant, in case someone in an urgent situation is identified. If no one meeting the urgent criteria is identified within 90 days, the slot will be made available for allocation to another CSB/BHA in the Health Planning Region (HPR). If there is no urgent need at the time that the HPR is to make a regional reallocation of a waiver slot, the HPR shall notify DMHMRSAS. DMHMRSAS shall have the authority to reallocate said slot to another HPR or CSB/BHA where there is unmet urgent need. Said authority must be exercised, if at all, within 30 days from receiving such notice.

2. Satisfaction of one or more of the following criteria shall indicate that the individual should be placed on the urgent need of waiver services list:

a. Both primary caregivers are 55 years of age or older, or if there is one primary caregiver, that primary caregiver is 55 years of age or older;

b. The individual is living with a primary caregiver, who is providing the service voluntarily and without pay, and the primary caregiver indicates that he can no longer care for the individual with mental retardation;

c. There is a clear risk of abuse, neglect, or exploitation;

d. A primary caregiver has a chronic or long-term physical or psychiatric condition or conditions which significantly limits the abilities of the primary caregiver or caregivers to care for the individual with mental retardation;

e. Individual is aging out of publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or

f. The individual with mental retardation lives with the primary caregiver and there is a risk to the health or safety of the individual, primary caregiver, or other individual living in the home due to either of the following conditions:

(1) The individual's behavior or behaviors present a risk to himself or others which cannot be effectively managed by the primary caregiver even with generic or specialized support arranged or provided by the CSB/BHA; or

(2) There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided by the CSB/BHA.

F. Reevaluation of service need and utilization review. Case managers shall complete reviews and updates of the CSP and level of care as specified in 12VAC30-120-215 D. Providers shall meet the documentation requirements as specified in 12VAC30-120-217 B.

12VAC30-120-215. Individual eligibility requirements.

A. Individuals receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.211, 435.217, and 435.230. The income level used for 42 CFR 435.211, 435.217 and 435.230 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of

care criteria. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and §1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the deductions listed below:

a. For individuals to whom §1924(d) applies and for whom Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual under both this waiver and the mental retardation day support waiver, which is equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)

(2) For an individual with only a spouse at home, the community spousal income allowance determined in accordance with §1924(d) of the Social Security Act.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with §1924(d) of the Social Security Act.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the plan.

b. For individuals to whom §1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual under both this waiver and the mental retardation day support waiver, which is equal to 165% of the SSI payment for one person. As of January 1, 2002, due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI. (The guardianship fee is not to exceed 5.0% of the individual's total monthly income.)

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children, which shall be equal to the Title XIX medically needy income standard based on the number of dependent children.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the State Medical Assistance Plan.

3. The following four criteria shall apply to all mental retardation waiver services:

a. Individuals qualifying for mental retardation waiver services must have a demonstrated need for the service resulting in significant functional limitations in major life activities. The need for the service must arise from either (i) an individual having a diagnosed condition of mental retardation or (ii) a child younger than six years of age being at developmental risk of significant functional limitations in major life activities;

b. The CSP and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be recommended by the case manager based on a current functional assessment using a DMHMRSAS approved assessment instrument and a demonstrated need for each specific service; and

d. Individuals qualifying for mental retardation waiver services must meet the ICF/MR level of care criteria.

B. Assessment and enrollment.

1. To ensure that Virginia's home and community-based waiver programs serve only individuals who would otherwise be placed in an ICF/MR, home and community-based

waiver services shall be considered only for individuals who are eligible for admission to an ICF/MR with a diagnosis of mental retardation, or who are under six years of age and at developmental risk. For the case manager to make a recommendation for waiver services, MR Waiver services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR, or promote exiting from either an ICF/MR placement or other institutional placement.

2. The case manager shall recommend the individual for home and community-based waiver services after completion of a comprehensive assessment of the individual's needs and available supports. This assessment process for home and community-based waiver services by the case manager is mandatory before Medicaid will assume payment responsibility of home and community-based waiver services. The comprehensive assessment includes:

a. Relevant medical information based on a medical examination completed no earlier than 12 months prior to the initiation of waiver services;

b. The case manager's functional assessment that demonstrates a need for each specific service. The functional assessment must be a DMHMRSAS approved assessment completed no earlier than 12 months prior to enrollment;

c. The level of care required by applying the existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.) completed no more than six months prior to enrollment. The case manager determines whether the individual meets the ICF/MR criteria with input from the individual and the individual's family/caregiver, as appropriate, and service and support providers involved in the individual's support in the community; and

d. A psychological evaluation or standardized developmental assessment for children under six years of age that reflects the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning of the individuals.

3. The case manager shall provide the individual and the individual's family/caregiver, as appropriate, with the choice of MR waiver services or ICF/MR placement.

4. The case manager shall send the appropriate forms to DMHMRSAS to enroll the individual in the MR Waiver or, if no slot is available, to place the individual on the waiting list. DMHMRSAS shall only enroll the individual if a slot is available. If no slot is available, the individual's name will be placed on either the urgent or nonurgent statewide waiting list until such time as a slot becomes available. Once notification has been received from DMHMRSAS that the individual has been placed on either the urgent or nonurgent waiting list, the case manager must notify the individual in writing within 10 business days of his placement on either list, and offer appeal rights. The case manager will contact the individual and the individual's family/caregiver, as appropriate, at least annually to provide the choice between institutional placement and waiver services while the individual is on the waiting list.

C. Waiver approval process: authorizing and accessing services.

1. Once the case manager has determined an individual meets the functional criteria for mental retardation (MR) waiver services, has determined that a slot is available, and that the individual has chosen MR waiver services, the case manager shall submit enrollment information to DMHMRSAS to confirm level of care eligibility and the availability of a slot.

2. Once the individual has been enrolled by DMHMRSAS, the case manager will submit a DMAS-122 along with a written confirmation from DMHMRSAS of level of care eligibility, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities.

3. After the case manager has received written notification of Medicaid eligibility by DSS and written confirmation of enrollment from DMHMRSAS, the case manager shall inform the individual and the individual's family/caregiver, as appropriate, so that the CSP can be developed. The individual and the individual's family/caregiver, as appropriate, will meet with the case manager within 30 calendar days to discuss the individual's needs and existing supports, and to develop a CSP that will establish and document the needed services. The case manager shall provide the individual and the individual's family/caregiver, as appropriate, with choice of needed services available under the MR Waiver, alternative settings and providers. A CSP shall be developed for the individual based on the assessment of needs as reflected in the level of care and functional assessment instruments and the individual's and the individual's family/caregiver's, as appropriate, preferences. The CSP development process identifies the services to be rendered to individuals, the frequency of services, the type of service provider or providers, and a description of the services to be offered.

4. The individual or case manager shall contact chosen service providers so that services can be initiated within 60 days of receipt of enrollment confirmation from DMHMRSAS. The service providers in conjunction with the individual and the individual's family/caregiver, as appropriate, and case manager will develop ISPs for each service. A copy of these plans will be submitted to the case manager. The case manager will review and ensure the ISP meets the established service criteria for the identified needs prior to submitting to DMHMRSAS for prior authorization. The ISP from each waiver service provider shall be incorporated into the CSP. Only MR Waiver services authorized on the CSP by DMHMRSAS according to DMAS policies may be reimbursed by DMAS.

5. The case manager must submit the results of the comprehensive assessment and a recommendation to the DMHMRSAS staff for final determination of ICF/MR level of care and authorization for community-based services. DMHMRSAS shall, within 10 working days of receiving all supporting documentation, review and approve, pend for more information, or deny the individual service requests. DMHMRSAS will communicate in writing to the case manager whether the recommended services have been approved and the amounts and type of services authorized or if any have been denied. Medicaid will not pay for any home and community-based waiver services

delivered prior to the authorization date approved by DMHMRSAS if prior authorization is required.

6. MR Waiver services may be recommended by the case manager only if:

a. The individual is Medicaid eligible as determined by the local office of the Department of Social Services;

b. The individual has a diagnosis of mental retardation as defined by the American Association on Mental Retardation, Mental Retardation: Definition, Classification, and System of Supports, 10th Edition, 2002, or is a child under the age of six at developmental risk, and would in the absence of waiver services, require the level of care provided in an ICF/MR the cost of which would be reimbursed under the Plan; and

c. The contents of the individual service plans are consistent with the Medicaid definition of each service.

7. All consumer service plans are subject to approval by DMAS. DMAS is the single state agency authority responsible for the supervision of the administration of the MR Waiver.

8. If services are not initiated by the provider within 60 days, the case manager must submit written information to DMHMRSAS requesting more time to initiate services. A copy of the request must be provided to the individual and the individual's family/caregiver, as appropriate. DMHMRSAS has the authority to approve the request in 30-day extensions, up to a maximum of four consecutive extensions, or deny the request to retain the waiver slot for that individual. DMHMRSAS shall provide a written response to the case manager indicating denial or approval of the extension. DMHMRSAS shall submit this response within 10 working days of the receipt of the request for extension.

D. Reevaluation of service need.

1. The consumer service plan (CSP).

a. The CSP shall be developed annually by the case manager with the individual and the individual's family/caregiver, as appropriate, other service providers, consultants, and other interested parties based on relevant, current assessment data.

b. The case manager is responsible for continuous monitoring of the appropriateness of the individual's services and revisions to the CSP as indicated by the changing needs of the individual. At a minimum, the case manager must review the CSP every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

c. Any modification to the amount or type of services in the CSP must be preauthorized by DMHMRSAS or DMAS.

2. Review of level of care.

a. The case manager shall complete a reassessment annually in coordination with the individual and the individual's family/caregiver, as appropriate,, and service providers. The reassessment shall include an update of the level of care and functional assessment instrument and any other appropriate assessment data. If warranted, the case manager shall coordinate a medical examination and a psychological evaluation for the individual. The CSP shall be revised as appropriate.

b. A medical examination must be completed for adults based on need identified by the individual and the individual's family/caregiver, as appropriate, provider, case manager, or DMHMRSAS staff. Medical examinations and screenings for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

c. A new psychological evaluation shall be required whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation. A psychological evaluation or standardized developmental assessment for children under six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities.

3. The case manager will monitor the service providers' ISPs to ensure that all providers are working toward the identified goals of the affected individuals.

4. Case managers will be required to conduct monthly onsite visits for all MR waiver individuals residing in DSS-licensed assisted living facilities or approved adult foster care placements.

5. The case manager must obtain an updated DMAS-122 form from DSS annually, designate a collector of patient pay when applicable and forward a copy of the updated DMAS-122 form to all service providers and the consumer-directed fiscal agent if applicable.

12VAC30-120-217. General requirements for home and community-based participating providers.

A. Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS and DMHMRSAS, in writing, of any change in the information that the provider previously submitted to DMAS and DMHMRSAS;

2. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid program at the time the service or services were performed;

3. Assure the individual's freedom to refuse medical care, treatment and services;

4. Accept referrals for services only when staff is available to initiate services and perform such services on an ongoing basis;

5. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC §2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§51.5-1 et seq. of the Code of Virginia); §504 of the Rehabilitation Act of 1973, as amended (29 USC§794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC §12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

6. Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

7. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS payment methodology from the individual's authorization date for the waiver services;

8. Use program-designated billing forms for submission of charges;

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided;

a. In general, such records shall be retained for at least six years from the last date of service or as provided by applicable state or federal laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

10. Agree to furnish information on request and in the form requested to DMAS, DMHMRSAS, the Attorney General of Virginia or his authorized representatives, federal

personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement;

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

12. Pursuant to 42 CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable state or federal law, hold confidential and use for authorized DMAS or DMHMRSAS purposes only all medical assistance information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the DMAS in conjunction with the cited laws;

13. Notify DMAS of change of ownership. When ownership of the provider changes, DMAS shall be notified at least 15 calendar days before the date of change;

14. For all facilities covered by §1616(e) of the Social Security Act in which home and community-based waiver services will be provided, be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS' licensure standards or through DSS-approved standards for adult foster care providers;

15. Suspected abuse or neglect. Pursuant to §§63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based waiver service individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DSS adult or child protective services worker and to DMHMRSAS Offices of Licensing and Human Rights as applicable; and

16. Adhere to the provider participation agreement and the DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the DMAS provider manual.

B. Documentation requirements.

1. The case manager must maintain the following documentation for utilization review by DMAS for a period of not less than six years from each individual's last date of service:

a. The comprehensive assessment and all CSPs completed for the individual;

b. All ISPs from every provider rendering waiver services to the individual;

c. All supporting documentation related to any change in the CSP;

d. All related communication with the individual and the individual's family/caregiver, as appropriate, consultants, providers, DMHMRSAS, DMAS, DSS, DRS or other related parties; and

e. An ongoing log that documents all contacts made by the case manager related to the individual and the individual's family/caregiver, as appropriate.

2. The service providers must maintain, for a period of not less than six years from the individual's last date of service, documentation necessary to support services billed. Utilization review of individual-specific documentation shall be conducted by DMAS staff. This documentation shall contain, up to and including the last date of service, all of the following:

a. All assessments and reassessments.

b. All ISP's developed for that individual and the written reviews.

c. Documentation of the date services were rendered and the amount and type of services rendered.

d. Appropriate data, contact notes, or progress notes reflecting an individual's status and, as appropriate, progress or lack of progress toward the goals on the ISP.

e. Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.

C. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides MR Waiver services for the individual.

12VAC30-120-219. Participation standards for home and community-based waiver services participating providers.

A. Requests for participation will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. For DMAS to approve provider agreements with home and community-based waiver providers, the following standards shall be met:

1. For services that have licensure and certification requirements, licensure and certification requirements pursuant to 42 CFR 441.302;

2. Disclosure of ownership pursuant to 42 CFR 455.104 and 455.105; and

3. The ability to document and maintain individual case records in accordance with state and federal requirements.

C. The case manager must inform the individual of all available waiver providers in the community in which he desires services and he shall have the option of selecting the provider of his choice from among those providers meeting the individual's needs.

D. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and periodically recertify each provider for participation agreement renewal with DMAS to provide home and community-based waiver services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's participation agreement, may result in a written request from DMAS for a corrective action plan that details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies that have been cited.

E. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS may terminate at will a provider's participation agreement on 30 days written notice as specified in the DMAS participation agreement. DMAS may also immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the program. Such action precludes further payment by DMAS for services provided to individuals subsequent to the date specified in the termination notice.

F. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

G. Section 32.1-325 of the Code of Virginia mandates that "any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, DC, must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. In addition, termination of a provider participation agreement will occur as may be required for federal financial participation.

H. Case manager's responsibility for the Individual Information Form (DMAS-122). It shall be the responsibility of the case management provider to notify DMHMRSAS and DSS, in writing, when any of the following circumstances occur. Furthermore, it shall be the responsibility of DMHMRSAS to update DMAS, as requested, when any of the following events occur:

1. Home and community-based waiver services are implemented.

2. A recipient dies.

3. A recipient is discharged from all MR waiver services.

4. Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 days.

5. A selection by the individual and the individual's family/caregiver, as appropriate, of a different community services board/behavioral health authority providing case management services.

I. Changes or termination of services. DMHMRSAS shall authorize changes to an individual's CSP based on the recommendations of the case management provider. Providers of direct service are responsible for modifying their ISPs with the involvement of the individual and the individual's family/caregiver, as appropriate, and submitting ISPs to the case manager any time there is a change in the individual's condition or circumstances which may warrant a change in the amount or type of service rendered. The case manager will review the need for a change and may recommend a change to the ISP to the DMHMRSAS staff. DMHMRSAS will review and approve, deny, or pend for additional information the requested change to the individual's ISP, and communicate this to the case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency, within three working days of receipt of the request for change.

The individual and the individual's family/caregiver, as appropriate, will be notified, in writing, of the right to appeal the decision or decisions to reduce, terminate, suspend or deny services pursuant to DMAS client appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC30-110. The case manager must submit this notification to the individual in writing within 10 business days of the decision. All CSPs are subject to approval by the Medicaid agency.

1. In a nonemergency situation, the participating provider shall give the individual and the individual's family/caregiver, as appropriate, and case manager 10 business days written notification of the provider's intent to discontinue services. The notification letter shall provide the reasons and the effective date the provider is discontinuing services. The effective date shall be at least 12 days from the date of the notification letter. The individual is not eligible for appeal rights in this situation and may pursue services from another provider.

2. In an emergency situation when the health and safety of the individual, other individuals in that setting, or provider personnel is endangered, the case manager and DMHMRSAS must be notified prior to discontinuing services. The 10 business day written notification period shall not be required. If appropriate, the local DSS adult protective services or child protective services and DMHMRSAS Offices of Licensing and Human Rights must be notified immediately.

3. In the case of termination of home and community-based waiver services by the CSB/BHA, DMHMRSAS or DMAS staff, individuals shall be notified of their appeal rights by the case manager pursuant to Part I (12VAC30-110-10 et seq.) of 12VAC30-110. The case manager shall have the responsibility to identify those individuals who no

longer meet the level of care criteria or for whom home and community-based waiver services are no longer an appropriate alternative.

12VAC30-120-221. Assistive technology.

A. Service description. AT is the specialized medical equipment and supplies including those devices, controls, or appliances, specified in the consumer service plan but not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in the individual's home, vehicle, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. AT shall be covered in the least expensive, most cost-effective manner.

C. Service units and service limitations. Assistive technology is available to individuals who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. The combined total of assistive technology items and labor related to these items may not exceed $5,000 per CSP year. Costs for assistive technology cannot be carried over from year to year and must be preauthorized each CSP year. AT shall not be approved for purposes of convenience of the caregiver or restraint of the individual. An independent professional consultation must be obtained from staff knowledgeable of that item for each AT request prior to approval by DMHMRSAS. All AT must be preauthorized by DMHMRSAS each CSP year.
Equipment/supplies/technology not available as durable medical equipment through the State Plan may be purchased and billed as assistive technology as long as the request for equipment/supplies/technology is documented and justified in the individual's ISP, recommended by the case manager, preauthorized by DMHMRSAS, and provided in the least expensive, most cost-effective manner.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, assistive technology shall be provided by a DMAS-enrolled Durable Medical Equipment provider or a DMAS-enrolled CSB/BHA with a MR Waiver provider agreement to provide assistive technology. The provider documentation requirements are as follows:

1. The appropriate ISAR form, to be completed by the case manager, may serve as the ISP, provided it adequately documents the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate

notation of evaluation or design, or both, labor, and supplies or materials, or both. The ISP/ISAR must include documentation of the reason that a rehabilitation engineer is needed, if one is to be involved. A rehabilitation engineer may be involved if disability expertise is required that a general contractor will not have. The ISAR must be submitted to DMHMRSAS for authorization to occur;

2. Written documentation regarding the process and results of ensuring that the item is not covered by the State Plan for Medical Assistance as durable medical equipment and supplies and that it is not available from a DME-provider when purchased elsewhere;

3. Documentation of the recommendation for the item by a qualified professional;

4. Documentation of the date services are rendered and the amount of service needed;

5. Any other relevant information regarding the device or modification;

6. Documentation in the case management record of notification by the designated individual or individual's representative of satisfactory completion or receipt of the service or item; and

7. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

12VAC30-120-223. Companion services.

A. Service description. Companion services provide nonmedical care, socialization, or support to an adult (age 18 or older). Companions may assist or support the individual with such tasks as meal preparation, community access and activities, laundry and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks. This service is provided in accordance with a therapeutic goal in the CSP and is not purely diversional in nature. This service may be provided either through an agency-directed or a consumer-directed model.

B. Criteria.

1. In order to qualify for companion services, the individual shall have demonstrated a need for assistance with IADLs, light housekeeping, community access, reminders for medication self-administration or support to assure safety. The provision of companion services does not entail hands-on care.

2. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-225.

C. Service units and service limitations.

1. The unit of service for companion services is one hour and the amount that may be included in the ISP shall not exceed eight hours per 24-hour day. There is a limit of 8 hours per 24-hour day for companion services, either agency or consumer-directed or combined.

2. A companion shall not be permitted to provide the care associated with ventilators, continuous tube feedings, or suctioning of airways.

3. The hours authorized are based on individual need. No more than two unrelated individuals who are receiving waiver services and live in the same home are permitted to share the authorized work hours of the companion.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, companion service providers must meet the following qualifications:

1. Companion services providers.

a. Agency-directed model: must be licensed by DMHMRSAS- as a residential service provider, supportive in-home residential service provider, day support service provider, or respite service provider or meet the DMAS criteria to be a personal care/respite care provider.

b. Consumer-directed model: a services facilitator meeting the requirements found in 12VAC30-120-225.

2. Companion qualifications. Companions must meet the following requirements:

a. Be at least 18 years of age;

b. Be able to read and write English and possess basic math skills;

c. Be capable of following an ISP with minimal supervision;

d. Submit to a criminal history record check within 15 days from the date of employment. The companion will not be compensated for services provided to the individual if the records check verifies the companion has been convicted of crimes described in §37.2-416 of the Code of Virginia;

e. Possess a valid Social Security number;

f. Be capable of aiding in instrumental activities of daily living; and

g. Receive an annual tuberculosis (TB) screening.

3. Companion service providers may not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective written documentation as to why there are no other providers available to provide the service. Companion services shall not be provided by adult foster care providers or any other paid caregivers for an individual residing in that home.

4. Family members who are reimbursed to provide companion services must meet the companion qualifications.

5. For the agency-directed model, companions will be employees of providers that will have participation agreements with DMAS to provide companion services. Providers will be required to have a companion services supervisor to monitor companion services. The supervisor must have a bachelor's degree in a human services field and at least one year of experience working in the mental retardation field, or be an LPN or an RN with at least one year of experience working in the mental retardation field. An LPN or RN must have a current license or certification to practice nursing in the Commonwealth within his profession.

6. The supervisor or services facilitator must conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of services and to establish an individual service plan for the individual. The supervisor or services facilitator must provide follow-up home visits to monitor the provision of services quarterly under the agency-directed model and semi-annually (every six months) under the consumer-directed model or as often as needed.

7. Required documentation in the individual's record. The provider or services facilitator must maintain a record of each individual receiving companion services. At a minimum these records must contain:

a. An initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation;

b. An ISP containing the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports, or both;

(2) The services to be rendered and the schedule of services to accomplish the above outcomes;

c. Documentation that the ISP goals, objectives, and activities have been reviewed by the provider or services facilitator quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

d. All correspondence to the individual and the individual's family/caregiver, as appropriate case manager, DMAS, and DMHMRSAS;

e. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual;

f. The companion services supervisor or services facilitator must document in the individual's record in a summary note following significant contacts with the companion and home visits with the individual that occur at least quarterly under the agency-directed model and at least semi-annually under the consumer-directed model:

(1) Whether companion services continue to be appropriate;

(2) Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;

(3) The individual's satisfaction with the service;

(4) The presence or absence of the companion during the supervisor's visit;

(5) Any suspected abuse, neglect, or exploitation and to whom it was reported; and

(6) Any hospitalization or change in medical condition, functioning, or cognitive status.

g. A copy of the most recently completed DMAS-122. The provider or services facilitator must clearly document efforts to obtain the completed DMAS-122 from the case manager.

h. Agency-directed provider companion records. In addition to the above requirements, the companion record for agency-directed providers must contain:

(1) The specific services delivered to the individual by the companion, dated the day of service delivery, and the individual's responses;

(2) The companion's arrival and departure times;

(3) The companion's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

(4) The companion's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

i. Consumer-directed model companion record. In addition to the above requirements outlined in subdivisions D 7 a through g of this section, the companion record for services facilitators must contain:

(1) The services facilitator's dated notes documenting any contacts with the individual and the individual's family/caregiver, as appropriate, and visits to the individual's home;

(2) Documentation of all training provided to the companion on behalf of the individual and the individual's family/caregiver, as appropriate;

(3) Documentation of all employee management training provided to the individual and the individual's family/caregiver, as appropriate, including the individual's and the individual's family/caregiver's, as appropriate, receipt of training on their responsibility for the accuracy of the companion's timesheets; and

(4) All documents signed by the individual and the individual's family/caregiver, as appropriate, that acknowledge the responsibilities as the employer.

12VAC30-120-225. Consumer-directed model of service delivery.

A. Criteria.

1. The MR Waiver has three services, companion, personal assistance, and respite, which may be provided through a consumer-directed model.

2. Individuals who choose the consumer-directed model must have the capability to hire and train their own personal assistants or companions and supervise the assistant's or companion's performance. If an individual is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

3. The individual, or if the individual is unable, then family/caregiver, shall be the employer in this service, and therefore shall be responsible for hiring, training, supervising, and firing assistants and companions. Specific employer duties include checking of references of personal assistants/companions, determining that personal assistants/companions meet basic qualifications, training assistants/companions, supervising the assistant's/companion's performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual and the individual's family/caregiver, as appropriate, must have a back-up plan in case the assistant/companion does not show up for work as expected or terminates employment without prior notice.

4. Individuals choosing consumer-directed models of service delivery must receive support from a CD services facilitator. This is not a separate waiver service, but is required in conjunction with consumer-directed personal assistance, respite, or companion services. The CD services facilitator will be responsible for assessing the individual's particular needs for a requested CD service, assisting in the development of

the ISP, providing training to the individual and the individual's family/caregiver, as appropriate, on his responsibilities as an employer, and providing ongoing support of the consumer-directed models of services. The CD services facilitator cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the assistant/companion. If an individual enrolled in consumer-directed services has a lapse in services facilitator for more than 90 consecutive days, the case manager must notify DMHMRSAS and the consumer-directed services will be discontinued.

5. DMAS shall provide for fiscal agent services for consumer-directed personal assistance services, consumer-directed companion services, and consumer-directed respite services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle the responsibilities of employment taxes for the individual. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the CD services facilitator must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitator and maintain provider status, the CD services facilitator shall have sufficient resources to perform the required activities. In addition, the CD services facilitator must have the ability to maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided.

2. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator have two years of satisfactory experience in a human service field working with persons with mental retardation. The facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the provider's application form, found in supporting documentation, or be observed during a job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that may occur in persons with mental retardation, or persons with other disabilities, as well as strategies to reduce limitations and health problems;

(2) Physical assistance that may be required by people with mental retardation, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that may be required by people with mental retardation that reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing home and ICF/MR placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance, respite, and companion services;

(5) MR waiver requirements, as well as the administrative duties for which the services facilitator will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in service planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed personal assistance, companion, and respite services, including hiring, training, managing, approving time sheets, and firing an assistant/companion;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and the individual's family/caregivers, as appropriate, and service providers;

(2) Assessing, supporting, observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to individuals with mental retardation; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for individuals who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing; and

(6) Develop a rapport and communicate with persons of diverse cultural backgrounds.

3. If the CD services facilitator is not a RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

a. For consumer-directed services, the CD services facilitator must make an initial comprehensive home visit to collaborate with the individual and the individual's family/caregiver, as appropriate, to identify the needs, assist in the development of the ISP with the individual and the individual's family/caregiver, as appropriate, and provide employee management training. The initial comprehensive home visit is done only once upon the individual's entry into the consumer-directed model of service regardless of the number or type of consumer-directed services that an individual chooses to receive. If an individual changes CD services facilitators, the new CD services facilitator must complete a reassessment visit in lieu of a comprehensive visit.

b. After the initial visit, the CD services facilitator will continue to monitor the companion or personal assistant ISP quarterly and on an as-needed basis. The CD services facilitator will review the utilization of consumer-directed respite services, either every six months or upon the use of 300 respite services hours, whichever comes first.

c. A face-to-face meeting with the individual must be conducted at least every six months to reassess the individual's needs and to ensure appropriateness of any CD services received by the individual.

5. During visits with the individual, the CD services facilitator must observe, evaluate, and consult with the individual and the individual's family/caregiver, as appropriate, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical needs, and social needs.

6. The CD services facilitator must be available to the individual by telephone.

7. The CD services facilitator must submit a criminal record check pertaining to the assistant/companion on behalf of the individual and report findings of the criminal record check to the individual and the individual's family/caregiver, as appropriate, and the program's fiscal agent. If the individual is a minor, the assistant/companion must also be screened through the DSS Child Protective Services Central Registry. Assistants/companions will not be reimbursed for services provided to the individual

effective the date that the criminal record check confirms an assistant/companion has been found to have been convicted of a crime as described in §37.2-416 of the Code of Virginia or if the assistant/companion has a confirmed record on the DSS Child Protective Services Central Registry. The criminal record check and DSS Child Protective Services Central Registry finding must be requested by the CD services facilitator within 15 calendar days of employment. The services facilitator must maintain evidence that a criminal record check was obtained and must make such evidence available for DMAS review.

8. The CD services facilitator shall review timesheets during the face-to-face visits or more often as needed to ensure that the number of ISP-approved hours is not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the individual to resolve discrepancies and must notify the fiscal agent.

9. The CD services facilitator must maintain a list of persons who are available to provide consumer-directed personal assistance, consumer-directed companion, or consumer-directed respite services.

10. The CD services facilitator must maintain records of each individual as described in 12VAC30-120-223 and 12VAC30-120-233.

11. Upon the individual's request, the CD services facilitator shall provide the individual and the individual's family/caregiver, as appropriate, with a list of persons who can provide temporary assistance until the assistant/companion returns or the individual is able to select and hire a new personal assistant/companion. If an individual is consistently unable to hire and retain the employment of an assistant/companion to provide consumer-directed personal assistance, companion, or respite services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the individual and the individual's family/caregiver, as appropriate, other service options.

12VAC30-120-227. Crisis stabilization services.

A. Crisis stabilization services involve direct interventions that provide temporary intensive services and support that avert emergency psychiatric hospitalization or institutional placement of persons with mental retardation who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services will include, as appropriate, neuro-psychiatric, psychiatric, psychological, and other functional assessments and stabilization techniques, medication management and monitoring, behavior assessment and positive behavioral support, and intensive service coordination with other agencies and providers. This service is designed to stabilize the individual and strengthen the current living situation, so that the individual remains in the community during and beyond the crisis period. These services shall be provided to:

1. Assist with planning and delivery of services and supports to enable the individual to remain in the community;

2. Train family/caregivers and service providers in positive behavioral supports to maintain the individual in the community; and

3. Provide temporary crisis supervision to ensure the safety of the individual and others.

B. Criteria.

1. In order to receive crisis stabilization services, the individual must meet at least one of the following criteria:

a. The individual is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;

b. The individual is experiencing extreme increase in emotional distress;

c. The individual needs continuous intervention to maintain stability; or

d. The individual is causing harm to self or others.

2. The individual must be at risk of at least one of the following:

a. Psychiatric hospitalization;

b. Emergency ICF/MR placement;

c. Immediate threat of loss of a community service due to a severe situational reaction; or

d. Causing harm to self or others.

C. Service units and service limitations. Crisis stabilization services may only be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional.

1. The unit for each component of the service is one hour. This service may only be authorized in 15-day increments but no more than 60 days in a calendar year may be used. The actual service units per episode shall be based on the documented clinical needs of the individual being served. Extension of services, beyond the 15-day limit per authorization, may only be authorized following a documented face-to-face reassessment conducted by a qualified mental retardation professional.

2. Crisis stabilization services may be provided directly in the following settings (examples below are not exclusive):

a. The home of an individual who lives with family, friends, or other primary caregiver or caregivers;

b. The home of an individual who lives independently or semi-independently to augment any current services and supports;

c. A community-based residential program to augment current services and supports;

d. A day program or setting to augment current services and supports; or

e. A respite care setting to augment current services and supports.

3. Crisis supervision is an optional component of crisis stabilization in which one-to-one supervision of the individual in crisis is provided by agency staff in order to ensure the safety of the individual and others in the environment. Crisis supervision may be provided as a component of crisis stabilization only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided one-to-one and face-to-face with the individual. Crisis supervision, if provided as a part of this service, shall be separately billed in hourly service units.

4. Crisis stabilization services shall not be used for continuous long-term care. Room, board, and general supervision are not components of this service.

5. If appropriate, the assessment and any reassessments, shall be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.

D. Provider requirements. In addition to the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the following crisis stabilization provider qualifications apply:

1. Crisis stabilization services shall be provided by providers licensed by DMHMRSAS as a provider of outpatient services, residential, or supportive in-home residential services, or day support services. The provider must employ or utilize qualified mental retardation professionals, licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities to individuals with mental retardation who are experiencing serious psychiatric or behavioral problems. The qualified mental retardation professional shall have: (i) at least one year of documented experience working directly with individuals who have mental retardation or developmental disabilities; (ii) a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession;

2. To provide the crisis supervision component, providers must be licensed by DMHMRSAS as providers of residential services, supportive in-home residential services, or day support services;

3. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving crisis stabilization services. At a minimum, the record must contain the following:

a. Documentation of the face-to-face assessment and any reassessments completed by a qualified mental retardation professional;

b. An ISP that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) The individual's goals;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. An ISP must be developed or revised and submitted to the case manager for submission to DMHMRSAS within 72 hours of the requested start date for authorization;

d. Documentation indicating the dates and times of crisis stabilization services, the amount and type of service or services provided, and specific information regarding the individual's response to the services and supports as agreed to in the ISP objectives; and

e. Documentation of qualifications of providers must be maintained for review by DMHMRSAS and DMAS staff.

12VAC30-120-229. Day support services.

A. Service description. Day support services shall include a variety of training, assistance, support, and specialized supervision for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. These services are typically offered in a nonresidential setting that allows peer interactions and community and social integration.

B. Criteria. For day support services, individuals must demonstrate the need for functional training, assistance, and specialized supervision offered primarily in settings other than the individual's own residence that allows an opportunity for being productive and contributing members of communities.

C. Types of day support. The amount and type of day support included in the individual's service plan is determined according to the services required for that individual. There are two types of day support: center-based, which is provided primarily at one location/building, or noncenter-based, which is provided primarily in community settings. Both types of day support may be provided at either intensive or regular levels.

D. Levels of day support. There are two levels of day support, intensive and regular. To be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) requires physical assistance to meet the basic personal care needs (toileting, feeding, etc); (ii) has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

E. Service units and service limitations. Day support services are billed in units. Units shall be defined as:

1. One unit is 1 to 3.99 hours of service a day.

2. Two units are 4 to 6.99 hours of service a day.

3. Three units are 7 or more hours of service a day.

Day support cannot be regularly or temporarily provided in an individual's home or other residential setting (e.g., due to inclement weather or individual illness) without prior written approval from DMHMRSAS. Noncenter-based day support services must be separate and distinguishable from either residential support services or personal assistance services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The supporting documentation must provide an estimate of the amount of day support required by the individual. Service providers are reimbursed only for the amount and level of day support services included in the individual's approved ISP based on the setting, intensity, and duration of the service to be delivered. This service shall be limited to 780 units per CSP year. If this service is used in combination with prevocational and /or group supported employment services, the combined total units for these services cannot exceed 780 units per CSP year.

F. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, day support providers need to meet additional requirements.

1. The provider of day support services must be licensed by DMHMRSAS as a provider of day support services.

2. In addition to licensing requirements, day support staff must also have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations. All providers of day support services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

3. Required documentation in the individual's record. The provider must maintain records of each individual receiving services. At a minimum, these records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the day support environment and community settings.

b. An ISP that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports and training needs;

(2) The individual's goals and measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives as appropriate;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. Documentation confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided.

d. Documentation indicating whether the services were center-based or noncenter-based.

e. Documentation regarding transportation. In instances where day support staff are required to ride with the individual to and from day support, the day support staff time can be billed as day support, provided that the billing for this time does not exceed 25% of the total time spent in the day support activity for that day. Documentation must be maintained to verify that billing for day support staff coverage during transportation does not exceed 25% of the total time spent in the day support for that day.

f. If intensive day support services are requested, documentation indicating the specific supports and the reasons they are needed. For ongoing intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.

g. Documentation indicating that the ISP goals, objectives, and activities have been reviewed by the provider quarterly, annually, and more often as needed. The results of the review must be submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

h. Copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-231. Environmental modifications.

A. Service description. Environmental modifications shall be defined as those physical adaptations to the home or vehicle, required by the individual's CSP, that are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Modifications can be made to an automotive vehicle if it is the primary vehicle being used by the individual. Modifications may be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program.

C. Service units and service limitations. Environmental modifications shall be available to individuals who are receiving at least one other waiver service in addition to targeted

mental retardation case management. A maximum limit of $5,000 may be reimbursed per CSP year. Costs for environmental modifications shall not be carried over from CSP year to CSP year and must be prior authorized by DMHMRSAS for each CSP year. Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repairs, central air conditioning, etc., and are not of direct medical or remedial benefit to the individual. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act. Adaptations that add to the total square footage of the home shall be excluded from this service.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, environmental modifications must be provided in accordance with all applicable federal, state or local building codes and laws by contractors of the CSB/BHA or providers who have a participation agreement with DMAS who shall be reimbursed for the amount charged by said contractors. The following are provider documentation requirements:

1. An ISP that documents the need for the service, the process to obtain the service, and the time frame during which the services are to be provided. The ISP must include documentation of the reason that a rehabilitation engineer or specialist is needed, if one is to be involved;

2. Documentation of the time frame involved to complete the modification and the amount of services and supplies;

3. Any other relevant information regarding the modification;

4. Documentation of notification by the individual and the individual's family/caregiver, as appropriate, of satisfactory completion of the service; and

5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed.

12VAC30-120-233. Personal assistance and respite services.

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal assistance services are provided to individuals in the areas of activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance. They may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community

activities. When specified, such supportive services may include assistance with instrumental activities of daily living (IADLs). Personal assistance does not include either practical or professional nursing services or those practices regulated in Chapters 30 (§54.1-3000 et seq.) and 34 (§54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

2. Respite services are supports for that which is normally provided by the family or other unpaid primary caregiver of an individual. These services are furnished on a short-term basis because of the absence or need for relief of those unpaid caregivers normally providing the care for the individuals.

B. Criteria.

1. In order to qualify for personal assistance services, the individual must demonstrate a need for assistance with activities of daily living, community access, self-administration of medications or other medical needs, or monitoring of health status or physical condition.

2. Respite services may only be offered to individuals who have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual.

C. Service units and service limitations.

1. The unit of service is one hour.

2. Each individual must have a back-up plan in case the personal assistant does not show up for work as expected or terminates employment without prior notice.

3. Personal assistance is not available to individuals: (i) who receive congregate residential services or live in assisted living facilities; (ii) who would benefit from personal assistance training and skill development; or (iii) who receive comparable services provided through another program or service.

4. Respite services shall not be provided to relieve group home or assisted living facility staff where residential care is provided in shifts. Respite services shall not be provided by adult foster care providers for an individual residing in that home. Training of the individual is not provided with respite services.

5. Respite services shall be limited to a maximum of 720 hours per calendar year. Individuals who are receiving services through both the agency-directed and consumer-directed model cannot exceed 720 hours per calendar year combined.

6. The hours authorized are based on individual need. No more than two unrelated individuals who live in the same home are permitted to share the authorized work hours of the assistant.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, personal assistance and respite providers must meet additional provider requirements:

1. Services shall be provided by:

a. For the agency-directed model, an enrolled DMAS personal care/respite care provider or by a DMHMRSAS-licensed residential services provider. In addition, respite services may be provided by a DMHMRSAS-licensed respite services provider or a DSS-approved foster care home for children or adult foster home provider. All personal assistants must pass an objective standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

b. For consumer-directed model, a services facilitator meeting the requirements found in 12VAC30-120-225.

2. For DMHMRSAS-licensed residential or respite services providers, a residential or respite supervisor will provide ongoing supervision of all assistants.

3. For DMAS-enrolled personal care/respite care providers, the provider must employ or subcontract with and directly supervise a RN or a LPN who will provide ongoing supervision of all assistants. The supervising RN or LPN must be currently licensed to practice nursing in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/MR or nursing facility.

4. The supervisor or services facilitator must make a home visit to conduct an initial assessment prior to the start of services for all individuals requesting personal assistance or respite services. The supervisor or services facilitator must also perform any subsequent reassessments or changes to the supporting documentation.

5. The supervisor or services facilitator must make supervisory home visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 to 90 days under the agency-directed model and semi-annually (every six months) under the consumer-directed model depending on the individual's needs.

a. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator is not required to conduct a supervisory visit every 30 to 90 days. Instead, the supervisor or services facilitator must conduct the initial home visit

with the respite assistant immediately preceding the start of services and make a second home visit within the respite period.

b. When respite services are routine in nature and offered in conjunction with personal assistance, the supervisory visit conducted for personal assistance may serve as the supervisory visit for respite services. However, the supervisor or services facilitator must document supervision of respite services separately. For this purpose, the same individual record can be used with a separate section for respite services documentation.

6. Based on continuing evaluations of the assistant's performance and individual's needs, the supervisor or services facilitator shall identify any gaps in the assistant's ability to function competently and shall provide training as indicated.

7. Qualification of assistants.

a. The assistant must:

(1) Be 18 years of age or older and possess a valid social security number;

(2) Be able to read and write English to the degree necessary to perform the tasks expected and possess basic math skills; and

(3) Have the required skills to perform services as specified in the individual's ISP.

b. Additional requirements for DMAS-enrolled personal care/respite care providers.

(1) Assistants must complete a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to an individual, the provider must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

(a) Registration as a certified nurse aide;

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistance, or home health aide;

(c) Completion of provider-offered training, which is consistent with the basic course outline approved by DMAS; and

(2) Assistants must have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children.

c. Additional requirements for the consumer-directed option. The assistant must:

(1) Submit to a criminal records check and, if the individual is a minor, consent to a search of the DSS Child Protective Services Central Registry. The assistant will not be compensated for services provided to the individual if either of these records checks verifies the assistant has been convicted of crimes described in §37.2-416 of the Code of Virginia or if the assistant has a founded complaint confirmed by the DSS Child Protective Services Central Registry;

(2) Be willing to attend training at the individual and the individual's family/caregiver, as appropriate, request;

(3) Understand and agree to comply with the DMAS MR Waiver requirements; and

(4) Receive an annual tuberculosis (TB) screening.

8. Assistants may not be the parents of individuals who are minors, or the individuals' spouses. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the service. Family members who are approved to be reimbursed for providing this service must meet the assistant qualifications.

9. Provider inability to render services and substitution of assistants (agency-directed model).

a. When an assistant is absent, the provider is responsible for ensuring that services continue to be provided to individuals. The provider may either provide another assistant, obtain a substitute assistant from another provider, if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider. The provider that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization is necessary.

b. If no other provider is available who can supply a substitute assistant, the provider shall notify the individual and the individual's family/caregiver, as appropriate, and case manager so that the case manager may find another available provider of the individual's choice.

c. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures must apply:

(1) The preauthorized provider must provide the supervision for the substitute assistant;

(2) The provider of the substitute assistant must send a copy of the assistant's daily documentation signed by the individual and the individual's family/caregiver, as appropriate, on his behalf and the assistant to the provider having the authorization; and

(3) The preauthorized provider must bill DMAS for services rendered by the substitute assistant.

d. If a provider secures a substitute assistant, the provider agency is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant.

10. Required documentation in the individual's record. The provider must maintain records regarding each individual receiving services. At a minimum these records must contain:

a. An initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated;

b. An ISP, that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) The individual's goals and objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives; and

(4) For the agency-directed model, the provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. The ISP goals, objectives, and activities must be reviewed by the supervisor or services facilitator quarterly for personal assistance only, annually, and more often as needed modified as appropriate and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual.

d. Dated notes of any contacts with the assistant, individual and the individual's family/caregiver, as appropriate, during supervisory or services facilitator visits to the individual's home. The written summary of the supervision or services facilitation visits must include:

(1) Whether services continue to be appropriate and whether the ISP is adequate to meet the need or if changes are indicated in the ISP;

(2) Any suspected abuse, neglect, or exploitation and to whom it was reported;

(3) Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;

(4) The individual's satisfaction with the service;

(5) Any hospitalization or change in medical condition or functioning status;

(6) Other services received and their amount; and

(7) The presence or absence of the assistant in the home during the supervisor's visit.

e. All correspondence to the individual and the individual's family/caregiver, as appropriate, case manager, DMAS, and DMHMRSAS;

f. Reassessments and any changes to supporting documentation made during the provision of services;

g. Contacts made with the individual, family/caregivers, physicians, formal and informal service providers, and all professionals concerning the individual;

h. Copy of the most recently completed DMAS-122 form. The provider or services facilitator must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

i. For the agency-directed model, the assistant record must contain:

(1) The specific services delivered to the individual by the assistant, dated the day of service delivery, and the individual's responses;

(2) The assistant's arrival and departure times;

(3) The assistant's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

(4) The assistant's and individual's and the individual's family/caregiver's, as appropriate, weekly signatures recorded on the last day of service delivery for any given week to verify that services during that week have been rendered.

j. For individuals receiving personal assistance and respite services in a congregate residential setting, because services that are training in nature are currently or no longer appropriate or desired, the record must contain:

(1) The specific services delivered to the individual, dated the day services were provided, the number of hours as outlined in the ISP, the individual's responses, and observations of the individual's physical and emotional condition; and

(2) At a minimum, monthly verification by the residential supervisor of the services and hours and quarterly verification as outlined in 12VAC30-120-241.

k. For the consumer-directed model, the assistant record must contain:

(1) Documentation of all training provided to the assistants on behalf of the individual and the individual's family/caregiver, as appropriate;

(2) Documentation of all employee management training provided to the individual and the individual's family/caregiver, as appropriate, including the individual and the individual's family/caregiver, as appropriate, receipt of training on their responsibility for the accuracy of the assistant's timesheets;

(3) All documents signed by the individual and the individual's family/caregiver, as appropriate, that acknowledge the responsibilities as the employer.

12VAC30-120-235. Personal Emergency Response System (PERS).

A. Service description. PERS is a service which monitors individual safety in the home and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. PERS may also include medication monitoring devices.

B. Criteria. PERS can be authorized when there is no one else in the home who is competent or continuously available to call for help in an emergency.

C. Service units and service limitations.

1. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service is the one-month rental price set by DMAS. The one-time installation of the unit includes installation, account activation, individual and caregiver instruction, and removal of PERS equipment.

2. PERS services must be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, PERS providers must also meet the following qualifications:

1. A PERS provider is a personal assistance agency, a durable medical equipment provider, a hospital, a licensed home health provider, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e. installation, equipment maintenance and service calls), and PERS monitoring.

2. The PERS provider must provide an emergency response center with fully trained operators who are capable of receiving signals for help from an individual's PERS equipment 24-hours a day, 365, or 366, days per year as appropriate, of determining whether an emergency exists, and of notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.

3. A PERS provider must comply with all applicable Virginia statutes, applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed.

4. The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit while the original equipment is being repaired.

5. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

6. The PERS installation includes local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

7. A PERS provider must maintain a data record for each PERS individual at no additional cost to DMAS. The record must document the following:

a. Delivery date and installation date of the PERS;

b. Individual or family/caregiver signature verifying receipt of PERS device;

c. Verification by a test that the PERS device is operational, monthly or more frequently as needed;

d. Updated and current individual responder and contact information, as provided by the individual, the individual's family/caregiver, or case manager; and

e. A case log documenting the individual's utilization of the system and contacts and communications with the individual, family/caregiver, case manager, and responders.

8. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

9. Standards for PERS equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637,

which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the individual.

10. A PERS provider must furnish education, data, and ongoing assistance to DMAS, DMHMRSAS and case managers to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the individual, family/caregiver, and responders in the use of the PERS service.

11. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by individuals who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

12. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to signals for help from multiple individuals' PERS equipment. The monitoring agency's equipment must include the following:

a. A primary receiver and a back-up receiver, which must be independent and interchangeable;

b. A back-up information retrieval system;

c. A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

f. A toll free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

13. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment, emergency response protocols, and recordkeeping and reporting procedures.

14. The PERS provider shall document and furnish within 30 days of the action taken a written report to the case manager for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or activations made in error.

15. The PERS provider is prohibited from performing any type of direct marketing activities to Medicaid recipients.

16. The provider must obtain and keep on file a copy of the most recently completed DMAS-122 form. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-237. Prevocational services.

A. Service description. Prevocational services are services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join the general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services, (excluding supported employment programs). Activities included in this service are not primarily directed at teaching specific job skills but at underlying habilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety.

B. Criteria. In order to qualify for prevocational services, the individual shall have a demonstrated need for support in skills that are aimed toward preparation of paid employment that may be offered in a variety of community settings.

C. Service units and service limitations. Billing is for one unit of service.

1. Units shall be defined as:

a. One unit is 1 to 3.99 hours of service a day.

b. Two units are 4 to 6.99 hours of service a day.

c. Three units are 7 or more hours of service a day.

This service is limited to 780 units per CSP year. If this service is used in combination with day support and /or group-supported employment services, the combined total units for these services cannot exceed 780 units per CSP year.

2. Prevocational services can be provided in center- or noncenter-based settings. Center-based means services are provided primarily at one location/building and noncenter-

based means services are provided primarily in community settings. Both center-based or noncenter-based prevocational services may be provided at either regular or intensive levels.

3. Prevocational services can be provided at either a regular or intensive level. For prevocational services to be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) require physical assistance to meet the basic personal care needs (toileting, feeding, etc); (ii) have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish service goals; or (iii) require extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. In this case, written behavioral objectives are required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

4. There must be documentation regarding whether prevocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). If the individual is not eligible for g services through the IDEA, documentation is required only for lack of DRS funding. When services are provided through these sources, the ISP shall not authorize them as a waiver expenditure.

5. Prevocational services can only be provided when the individual's compensation is less than 50% of the minimum wage.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, prevocational providers must also meet the following qualifications:

1. The provider of prevocational services must be a vendor of extended employment services, long-term employment services, or supported employment services for DRS, or be licensed by DMHMRSAS as a provider of day support services.

2. Providers must ensure and document that persons providing prevocational services have training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for persons with mental retardation and functional limitations. All providers of prevocational services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

3. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving prevocational services. At a minimum, the records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the prevocational environment and community settings.

b. An ISP, which contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports, and training needs;

(2) The individual's goals and measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. Documentation indicating that the ISP goals, objectives, and activities have been reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and that the results of these reviews have been submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

d. Documentation confirming the individual's attendance, amount of time spent in services, and type of services rendered, and specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided.

e. Documentation indicating whether the services were center-based or noncenter-based.

f. Documentation regarding transportation. In instances where prevocational staff are required to ride with the individual to and from prevocational services, the prevocational staff time can be billed for prevocational services, provided that billing for this time does not exceed 25% of the total time spent in prevocational services for that day. Documentation must be maintained to verify that billing for prevocational staff coverage during transportation does not exceed 25% of the total time spent in the prevocational services for that day.

g. If intensive prevocational services are requested, documentation indicating the specific supports and the reasons they are needed. For ongoing intensive prevocational services, there must be clear documentation of the ongoing needs and associated staff supports.

h. Documentation indicating whether prevocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA).

i. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-241. Residential support services.

A. Service description. Residential support services consist of training, assistance or specialized supervision provided primarily in an individual's home or in a licensed or approved residence to enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Service providers shall be reimbursed only for the amount and type of residential support services included in the individual's approved ISP. Residential support services shall be authorized in the ISP only when the individual requires these services and these services exceed the services included in the individual's room and board arrangements for individuals residing in group homes, or, for other individuals, if these services exceed supports provided by the family/caregiver. Services will not be routinely reimbursed for a continuous 24-hour period.

B. Criteria.

1. In order for Medicaid to reimburse for residential support services, the individual shall have a demonstrated need for supports to be provided by staff who are paid by the residential support provider.

2. In order to qualify for this service in a congregate setting, the individual shall have a demonstrated need for continuous training, assistance, and supervision for up to 24 hours per day.

3. A functional assessment must be conducted to evaluate each individual in his home environment and community settings.

4. The residential support ISP must indicate the necessary amount and type of activities required by the individual, the schedule of residential support services, and the total number of projected hours per week of waiver reimbursed residential support.

C. Service units and service limitations. Total billing cannot exceed the authorized amount in the ISP. The provider must maintain documentation of the date and times that services were provided, and specific circumstances that prevented provision of all of the scheduled services.

1. This service must be provided on an individual-specific basis according to the ISP and service setting requirements;

2. Congregate residential support services may not be provided to any individual who receives personal assistance services under the MR Waiver or other residential services that provide a comparable level of care. Respite services may be provided in conjunction with in-home residential support services to unpaid caregivers.

3. Room, board, and general supervision shall not be components of this service;

4. This service shall not be used solely to provide routine or emergency respite for the family/caregiver with whom the individual lives; and

5. Medicaid reimbursement is available only for residential support services provided when the individual is present and when a qualified provider is providing the services.

D. Provider requirements.

1. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, the provider of residential services must have the appropriate DMHMRSAS residential license.

2. Residential support services may also be provided in adult foster care homes approved by local DSS offices pursuant to state DSS regulations.

3. In addition to licensing requirements, persons providing residential support services are required to participate in training in the characteristics of mental retardation and appropriate interventions, training strategies, and support methods for individuals with mental retardation and functional limitations. All providers of residential support services must pass an objective, standardized test of skills, knowledge, and abilities approved by DMHMRSAS and administered according to DMHMRSAS' defined procedures.

4. Required documentation in the individual's record. The provider agency must maintain records of each individual receiving residential support services. At a minimum these records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the residential environment and community settings.

b. An ISP containing the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports, or both, and training needs;

(2) The individual's goals and measurable objectives to meet the above identified outcomes;

(3) The services to be rendered and the schedule of services to accomplish the above goals, objectives, and desired outcomes;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) The provider staff responsible for the overall coordination and integration of the services specified in the ISP.

c. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

d. Documentation must confirm attendance, the amount of time in services, and provide specific information regarding the individual's response to various settings and supports as agreed to in the ISP objectives.

e. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-245. Skilled nursing services.

A. Service description. Skilled nursing services shall be provided for individuals with serious medical conditions and complex health care who do not meet home health criteria needs that require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the individual's home or other community setting on a regularly scheduled or intermittent need basis. It may include consultation, nurse delegation as appropriate, oversight of direct care staff as appropriate, and training for other providers.

B. Criteria. In order to qualify for these services, the individual shall have demonstrated complex health care needs that require specific skilled nursing services ordered by a physician and that cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance. The CSP must indicate that the service is necessary in order to prevent institutionalization and is not available under the State Plan for Medical Assistance.

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units. The services must be

explicitly detailed in an ISP and must be specifically ordered by a physician as medically necessary to prevent institutionalization.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, participating skilled nursing providers must meet the following qualifications:

1. Skilled nursing services shall be provided by either a DMAS-enrolled home care organization provider or home health provider, or by a registered nurse licensed by the Commonwealth or licensed practical nurse licensed by the Commonwealth (under the supervision of a registered nurse licensed by the Commonwealth), contracted or employed by DMHMRSAS-licensed day support, respite, or residential providers.

2. Skilled nursing services providers may not be the parents of individuals who are minors, or the individual's spouse. Payment may not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who provide skilled nursing services must meet the skilled nursing requirements.

3. Foster care providers may not be the skilled nursing services providers for the same individuals to whom they provide foster care.

4. Required documentation. The provider must maintain a record that contains:

a. An ISP that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required or desired supports;

(2) The individual's goals;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) The estimated duration of the individual's needs for services; and

(5) The provider staff responsible for the overall coordination and integration of the services specified in the ISP;

b. Documentation of any training of family/caregivers or staff, or both, to be provided, including the person or persons being trained and the content of the training, consistent with the Nurse Practice Act;

c. Documentation of the determination of medical necessity by a physician prior to services being rendered;

d. Documentation of nursing license/qualifications of providers;

e. Documentation indicating the dates and times of nursing services and the amount and type of service or training provided;

f. Documentation that the ISP was reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual.

g. Documentation that the ISP has been reviewed by a physician within 30 days of initiation of services, when any changes are made to the ISP, and also reviewed and approved annually by a physician; and

h. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

12VAC30-120-247. Supported employment services.

A. Service description.

1. Supported employment services are provided in work settings where persons without disabilities are employed. It is especially designed for individuals with developmental disabilities, including individuals with mental retardation, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential.

2. Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without ongoing supports and who because of their disability need ongoing support to perform in a work setting.

3. Supported employment can be provided in one of two models. Individual supported employment shall be defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position. Group supported employment shall be defined as continuous support provided by staff to eight or fewer individuals with disabilities in an enclave, work crew, bench work, or entrepreneurial model. The individual's assessment and CSP must clearly reflect the individual's need for training and supports.

B. Criteria.

1. Only job development tasks that specifically include the individual are allowable job search activities under the MR waiver supported employment and only after determining this service is not available from DRS.

2. In order to qualify for these services, the individual shall have demonstrated that competitive employment at or above the minimum wage is unlikely without ongoing supports, and that because of his disability, he needs ongoing support to perform in a work setting.

3. A functional assessment must be conducted to evaluate the individual in his work environment and related community settings.

4. The ISP must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the individual's ISP based on the intensity and duration of the service delivered.

C. Service units and service limitations.

1. Supported employment for individual job placement is provided in one hour units. This service is limited to 40 hours per week.

2. Group models of supported employment (enclaves, work crews, bench work and entrepreneurial model of supported employment) will be billed at the unit rate. For group models of supported employment, units shall be defined as:

a. One unit is 1 to 3.99 hours of service a day.

b. Two units are 4 to 6.99 hours of service a day.

c. Three units are 7 or more hours of service a day.

This service is limited to 780 units per CSP year. If this service is used in combination with prevocational and day support services, the combined total units for these services cannot exceed 780 units per CSP year.

3. For the individual job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the individual is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, supported employment provider qualifications include:

1. Supported employment shall be provided only by agencies that are DRS vendors of supported employment services;

2. Required documentation in the individual's record. The provider must maintain a record regarding each individual receiving supported employment services. At a minimum, the records must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the supported employment environment and related community settings.

b. Documentation indicating individual ineligibility for supported employment services through DRS or IDEA. If the individual is not eligible through IDEA, documentation is required only for the lack of DRS funding;

c. An ISP that contains, at a minimum, the following elements:

(1) The individual's strengths, desired outcomes, required/desired supports and training needs;

(2) The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

(3) Services to be rendered and the frequency of services to accomplish the above goals and objectives;

(4) A timetable for the accomplishment of the individual's goals and objectives;

(5) The estimated duration of the individual's needs for services; and

(6) Provider staff responsible for the overall coordination and integration of the services specified in the plan.

d. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and the results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

e. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time can be billed for supported employment provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day. Documentation must be maintained to verify that billing for supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.

f. There must be a copy of the completed DMAS-122 in the record. Providers must clearly document efforts to obtain the DMAS-122 form from the case manager.

12VAC30-120-249. Therapeutic consultation.

A. Service description. Therapeutic consultation provides expertise, training and technical assistance in any of the following specialty areas to assist family members,

caregivers, and other service providers in supporting the individual. The specialty areas are (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services, is based on the individual's CSP, and provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their ability to function in the community. Therapeutic consultation services may be provided in the individual's home, and in appropriate community settings and are intended to facilitate implementation of the individual's desired outcomes as identified in his CSP.

B. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the CSP cannot be implemented effectively and efficiently without such consultation from this service.

1. The individual's therapeutic consultation ISP must clearly reflect the individual's needs, as documented in the social assessment, for specialized consultation provided to family/caregivers and providers in order to implement the ISP effectively.

2. Therapeutic consultation services may not include direct therapy provided to waiver individuals or monitoring activities, and may not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the ISP. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring. Only behavioral consultation may be offered in the absence of any other waiver service when the consultation is determined to be necessary to prevent institutionalization.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-217 and 12VAC30-120-219, professionals rendering therapeutic consultation services shall meet all applicable state or national licensure, endorsement or certification requirements. Persons providing rehabilitation consultation shall be rehabilitation engineers or certified rehabilitation specialists. Behavioral consultation may be performed by professionals based on the professionals' work experience, education, and demonstrated knowledge, skills, and abilities.

The following documentation is required for therapeutic consultation:

1. An ISP, that contains at a minimum, the following elements:

a. Identifying information:

b. Targeted objectives, time frames, and expected outcomes; and

c. Specific consultation activities.

2. A written support plan detailing the recommended interventions or support strategies for providers and family/caregivers to use to better support the individual in the service.

3. Ongoing documentation of consultative services rendered in the form of contact-by-contact or monthly notes that identify each contact.

4. If the consultation service extends beyond the one year, the ISP must be reviewed by the provider with the individual receiving the services and the case manager, and this written review must be submitted to the case manager, at least annually, or more as needed. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and are to be forwarded to the case manager. Any changes to the ISP must be reviewed with the individual and the individual's family/caregiver, as appropriate.

5. A copy of the most recently completed DMAS-122. The provider must clearly document efforts to obtain a copy of the completed DMAS-122 from the case manager.

6. A final disposition summary that must be forwarded to the case manager within 30 days following the end of this service.